DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Disability and Elder Services
DDE- 2500 (Rev. 7-03)

FIRE REPORT

All incidents of fire in a nursing home, facility for the developmentally disabled (FDD), community based residential facility (CBRF), hospital or adult family home must be reported to the Department within 72 hours per HFS 132.82(6)(e), HFS 134.82(4)(e), HFS 83.19(3)(a), HFS 124.36(11), HFS 88.05(4)(e), and s.50.035(4), Stats. Information about the fire may be reported by completing and submitting this form; however, it is not mandatory that you use this form. Include sketches, photographs, reports or statements, if available. Questions about completion of this form may be directed to the Fire Authority at 608-261-5993. Mail the form and attachments to:

FIRE AUTHORITY
Bureau of Quality Assurance
Provider Regulation and Quality Improvement Section
PO Box 2969
Madison WI 53701-2969

Name of Facility	License / Provider Number
Address	Date of Fire
City	Time of Fire ☐ AM ☐ PM

TYPE OF PROVIDER ☐ nursing home ☐ FDD ☐ CBRF ☐ hospital ☐ adult family home

Type of fire (Provide narrative description—use the back of this form to provide additional information)

Location of fire in the facility

Was anyone injured? ☐ yes ☐ no	TOTAL NO. INJURED	NO. OF RESIDENTS	NO. OF STAFF	NO. OF OTHERS

Residents were evacuated from: ☐ room ☐ floor ☐ wing ☐ building

Residents were, or are, relocated to other facilities or locations? ☐ yes ☐ no

Was the fire alarm system activated? ☐ yes ☐ no	**METHOD OF ACTIVATION** ☐ manual pull station ☐ heat detector ☐ smoke detector ☐ sprinkler system
Number of sprinkler heads activated	Was a follow-up call made to the fire department? ☐ yes ☐ no
Fire department responded? ☐ yes ☐ no	Fire extinguished by: ☐ staff ☐ fire dept. ☐ others

Method of fire extinguishment

Is the fire alarm system restored to normal working condition? ☐ yes ☐ no

Is the sprinkler system restored to normal operation condition? ☐ yes ☐ no

Estimated cost of repairs

Name and Title of Person Completing This Report	Telephone Number
Signature of Person Completing This Report	Date Report Completed